Questions by
Chairman Tom Coburn for
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1. What do you think are the most important areas that OIG can identify that should be strengthened to improve overall Medicaid integrity efforts? What efforts has OIG made to identify past vulnerabilities in the Medicaid integrity program?

Answer. Areas that would improve the integrity of the Medicaid program include encouraging States to develop better methods for preventing and identifying payment and eligibility errors and encouraging CMS to continue its efforts to curb State financing mechanisms that inflate the Federal share of Medicaid in ways that were not intended by Congress. We believe continued investigation of pharmaceutical manufacturer fraud and anti-kickback and quality of care violations also contribute to overall Medicaid program integrity.

In the past five years, OIG has expended significant resources to successfully focus on State financing mechanisms. We have audited issues such as upper payment limits, intergovernmental transfers, and disproportionate share hospital payments, resulting in hundreds of millions of dollars in questioned costs and billions in funds put to better use. As a related matter, we are studying States' use of consultants on a contingency fee basis with the intent of inappropriately inflating Federal reimbursements.

In other areas, OIG is currently conducting audits of Medicaid eligibility errors in three States; we are looking at the inappropriate payments of specific benefits including dental and transportation services; and we plan to continue to monitor CMS's process for measuring Medicaid payment errors.

2. What is the role of OIG in identifying improper payments in Medicare and Medicaid?

Answer. The identification of improper payments in Medicare and Medicaid has always been a primary focus of OIG. As our semiannual reports to Congress highlight, we continuously review health care issues to identify program overpayments to be recovered and to identify the vulnerabilities that lead to improper payments. OIG findings have identified improper payments in areas such as Medicaid hospital disproportionate share payments, State calculations of upper payment limit funding pools, Medicaid school based services claims, improper use of consultants in Medicaid claims submissions, hospital compliance with Medicare's postacute care transfer policy, chiropractic services in the Medicare program, and payments for durable medical equipment rentals and purchases by Medicare beneficiaries. For the 6-month period ending September 30, 2005 (the latest semiannual report), we issued reports recommending collection of over $710 million in improper payments, and CMS agreed with the recovery of over $762 million that had been identified in prior reports.

In addition, in collaboration with CMS, OIG developed the first comprehensive Medicare improper payment rate as part of the annual financial statement audit of Medicare operations. We have either calculated or monitored this annual improper payment rate in

each year since 1996. We are presently assisting CMS in its planning for a similar payment error rate for Medicaid. CMS plans to include these Medicaid improper payment determinations as part of the fiscal year 2007 financial statement report.

3. What efforts has OIG made to collect data on improper payments in Medicaid? Fraudulent payments?

Answer. For the last several years, OIG has worked closely with CMS and the Office of Management and Budget in helping to identify an approach to determine an annual Medicaid improper payment rate. CMS is finalizing a core set of requirements that a sample of States will use each year to calculate a national Medicaid error rate. We will continue to monitor these CMS and State activities to help ensure that accurate rates are calculated.

Public Law 107-300, known as the Improper Payments Information Act of 2002, requires the head of each agency to estimate the annual amount of improper payments, and report on what actions the agency is taking to reduce improper payments. OIG does not identify improper payment rates in Medicaid or Medicare but monitors and oversees the methodology CMS uses in all its programs to estimate improper payment rates. CMS is currently working towards implementing the Payment Error Rate Measurement Program (PERM), detailing the methodology to estimate improper payments in the Medicaid, managed care, and State Children's Health Insurance Programs. We are working with CMS through this process and will begin our oversight responsibilities when the PERM is fully operational.

The objective of many of our audits and evaluations is to identify improper payments or to highlight areas vulnerable to abuse by providers. However, improper payments identified through these reviews are not necessarily indicative of fraud. Although audits and evaluations will occasionally identify fraud, they are not typically designed for that purpose. Extensive investigative steps are needed to bring a criminal or civil fraud case against a provider.

Fraud is an undetermined subset of improper payments. Non-fraudulent causes of improper payments include errors, lack of knowledge about existing rules, or misunderstanding of policies. Estimating a fraud rate is almost impossible to calculate because fraud reflects a legal definition involves establishing intent and weighing the merits of a case against standards. A billing instance or pattern may be improper but not necessarily fraudulent. Conversely, false documentation related to claims for payment may appear on the surface to be correct. Further, many allegations of fraud are settled without admissions of guilt or formal determinations of wrongdoing, and, therefore, would not be categorized as fraudulent.

OIG works closely with the State Medicaid Fraud Control Units (MFCUs) to identify and bring to justice those providers who have attempted to defraud the Medicaid Program. We periodically publish reports of the MFCUs' operations that provide statistical summaries by unit and information on individual fraud actions completed during the reporting period.

4. What is the biggest program integrity problem - provider fraud or questionable State practices to increase matching funds? What is OIG's strategy for dealing with both of these problems?

Answer. Both are equally significant problems. In recent years, we have expended a significant amount of resources auditing questionable State practices to increase matching funds. The areas we audited included upper payment limits, intergovernmental transfers, disproportionate share hospital payments, and contingency fee payment arrangements. Our presence in these areas will continue and we also plan to expand our work to new financing areas, such as provider taxes and certified public expenditures.

From an investigative perspective, OIG's role in identifying fraud is similar in both Medicare and Medicaid; however, our primary partners differ between the two programs. In Medicare, OIG works primarily with the CMS Program Integrity Group and the Program Safeguard Contractors to identify areas of vulnerability and problem providers. On the Medicaid side, our role is similar; however, we work with the State Agency's Surveillance and Utilization Review Subsystem (SURS) units, the MFCUs, and sometimes State Inspectors General to identify instances and patterns of potential fraud. For both programs, our goals include detecting and addressing fraudulent activity, as well as identifying vulnerabilities to fraud and recommending actions to remedy the vulnerabilities and prevent future fraud.

With the Medicaid-specific funding provided by the Deficit Reduction Act (DRA), OIG plans to increase its identification and review of providers with aberrant billing patterns. The increased use of software applications will help OIG identify leads to Medicaid fraud, as well as improper payments. In coming months, our work priorities will include reimbursements for pharmaceuticals, dental services, home health care services, durable medical equipment supplies, and psychiatric services.

5. What are the lessons learned from efforts to combat fraud and abuse in the Medicare program that OIG could apply to new Medicaid program integrity initiatives?

Answer. The addition of the new Medicaid program integrity initiative will offer OIG many opportunities to apply what we have learned from our Medicare experience and build upon our successes in that program. For example, our Medicare experience has taught us that vulnerabilities lie in areas where provider enrollment is easy and where licensure is not required, such as with durable medical equipment suppliers and home health agencies. OIG's agents have gained wide-ranging experience in the investigation of Medicare fraud and are able to apply the successes of the past to their increasing presence in the Medicaid environment. The Medicaid program covers many of the goods and services that are also covered by the Medicare program. Therefore, agents can transition from one focus to another.

Medicaid does offer some unique benefits that do not directly correspond to Medicare coverage. For example, the Medicare and Medicaid programs cover different transportation services. Under Medicare, transportation reimbursement is primarily limited to ambulance transport. Under Medicaid, reimbursable transports also include other forms of travel such as taxis and community buses.

6. Do you have any issues or concerns with how CMS may organize Medicaid anti-fraud and abuse activities within the agency following the implementation of the recently passed DRA?

Answer. We understand that CMS is currently preparing a detailed plan for organizing its Medicaid anti-fraud and abuse activities. We have had some preliminary discussions with CMS regarding its plan, but because the plan has not yet been finalized we do not have any issues or concerns to discuss at this time.

7. How does OIG rate the effectiveness of State audit initiatives? How often are program integrity reviews of State Medicaid agencies conducted? When can we expect to see similar activities on a much more comprehensive and regular basis?

Answer. OIG interacts with State auditors in two ways. First, we work with them in implementing the requirements of the Single Audit Act and OMB Circular A-133, which establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities are required to have annual organization-wide audits. OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. Overall, we have found these audits to be in compliance with Federal requirements. Second, we have an ongoing initiative to work more closely with State auditors in reviewing program issues in Medicaid. To this end, a partnership plan was developed to foster joint reviews between OIG and State auditors to provide broader coverage of the Medicaid program. To date, partnerships have been developed in 25 States, the results of which have identified over $263 million in Federal and State possible savings.

8. Do Medicaid Fraud Control Units report that Medicaid agency referrals are inadequate in many States? What efforts are being made to encourage States to increase referrals and coordination between agencies in this area?

Answer. MFCUs report to us on a quarterly basis the number of referrals by their State's Medicaid agency, as well as by other sources both within and outside the State. State agency referrals generally appear to be lower than would be expected. In all States, the SURS units apply automated postpayment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or abuse. When potential fraud cases are detected, the State Agency is required to refer the cases to the State's MFCU. We currently have work in progress to review performance indicators for Medicaid fraud referrals. As part of this study, we are examining data on referrals by State Medicaid agencies and acceptance of those referrals by MFCUs.

There are a number of methods MFCUs use to increase the number of referrals and other leads, including such things as caller "hotlines" to report complaints of alleged Medicaid fraud and patient abuse and neglect; outreach to the State's medical board, nursing board, licensing authorities, and other agencies; maintaining a web-page for public use; and outreach activities to groups such as the medical community, elder advocacy groups, and other law enforcement agencies. The extent of these activities varies among the 49 MFCUs.

9. Under the DRA, what efforts are being made to encourage the critical role of whistleblowers, concerned citizens, etc.?

Answer. OIG will draft standards for reviewing State false claims acts and will begin reviewing existing State laws before January 1, 2007. The DRA requires OIG to determine, in consultation with the Department of Justice, whether a State has in effect a law that meets certain requirements that parallel those contained in the Federal False Claims Act. If the State law meets those requirements, the Federal percentage of amounts recovered under such laws shall be decreased by 10 percent. OIG has already received a number of inquiries from State legislatures and State Attorneys General offices regarding particular State laws. OIG intends to draft standards of review, to be published as a notice (without comment) in the Federal Register, and then begin its review of existing State laws.

10. With the recent passage of the DRA, do you expect that OIG will shift focus somewhat from Medicare program integrity to a greater emphasis on monitoring State Medicaid fraud control efforts? Why is it that Medicare program integrity efforts are so much more developed than Medicaid?

Answer. With the passage of the DRA, OIG has been provided additional funds to review the Medicaid program, and we will be expanding our efforts to monitor Medicaid fraud control efforts. While OIG is in the process of planning for this expanded effort in Medicaid, Medicare remains the primary focus of our resources. Medicare program integrity efforts may appear to be more developed because there are national policies followed in operating the Medicare program, and Medicare utilizes a long established network of contractors (fiscal intermediaries and carriers) to process all Medicare claims transactions and accounting operations.

While Medicaid is operated within Federal rules that require each State to submit a plan for approval, there are differences in how States operate their programs, including program integrity and safeguard systems and activities. Moreover, States can apply to waive certain Federal requirements. In the past, States have used these waivers to expand programs. More recently, States have used waivers to change eligibility rules in order to limit those covered. A State can also request to modify the Federal rules through issuance of State plan amendments. The nature of these waivers and plan amendments, coupled with the different methods that States use to pay claims and operate their computer systems, makes it more difficult to review Medicaid on a national basis.

In addition to OIG's general Medicaid oversight work, we have responsibility for administering grants to fund MFCUs' ongoing operations. The States are reimbursed for MFCUs' operations at a rate of 90 percent of costs for the first 3 years after the Unit's initial certification by OIG and 75 percent thereafter. Thus far in FY 2006, OIG has awarded approximately $159.1 million in grant funds to MFCUs. In FY 2005, about $144.3 million was awarded to MFCUs.

OIG's responsibilities for oversight of the funding and operation standards of MFCUs include monitoring their overall performance and productivity and ensuring that they devote their full-time efforts to Medicaid-covered health care fraud and patient abuse. In

FY 2005, OIG conducted joint investigations with MFCUs on 331 criminal cases and 95 civil cases and achieved 54 convictions and 28 settlements or judgments in civil cases.

11. Does OIG support a strong emphasis on data mining between critical agencies, e.g., Medicare and Medicaid? Are all States being encouraged to support a strong emphasis on data mining?

Answer. OIG strongly supports data mining efforts both within a program and between multiple programs. We have utilized data mining software techniques in many of our activities. OIG supports the present effort by CMS to compare data between the Medicare and Medicaid programs (called Medi-Medi), and we continue to work closely with CMS, through its contractors and the MFCUs, to pursue the identified aberrant providers. While we believe that CMS has encouraged States to incorporate data mining techniques in reviewing their Medicaid claims process, CMS would have to provide details on which States have instituted data mining activities in their operations.

12. Because Medicaid is a needs-based program, a robust eligibility component should be factored into the improper payment rate calculation. Does such a component currently exist?

Answer. CMS is working on developing a Medicaid eligibility component to be factored into the improper payment rate calculation. The first Medicaid eligibility component error rate to be factored into the improper payment rate calculation will be reported as part of the annual financial statement report in 2008. CMS is currently drafting the interim final PERM regulation to be published in August 2006. The PERM regulation includes the process to measure a Medicaid and State Children's Health Insurance Program fee-for- service, managed care and eligibility error rates. The first national Medicaid error rate that includes an eligibility component error rate will be published in the Department of Health and Human Services' Performance and Accountability Report in November 2008.

13. Does OIG have suggestions for improving Medicaid program integrity that have not yet been implemented (limitations for Upper Payment Rules; facility-specific limits to cap the amount of enhanced payments sent to any one facility, etc.)? If so, please detail.

Answer. We have previously recommended that Medicaid payments returned to States by public providers should be declared refunds, facility-specific limits should be based on actual cost data rather than aggregate limits, and CMS should establish regulations regarding disproportionate share hospital payments. These prior recommendations and others are described in detail in OIG's 2005 Red Book. Similarly, OIG's Orange Book is a compendium of significant unimplemented, nonmonetary recommendations for improving departmental operations. These publications are available on OIG's Web site at the following addresses:

http://www.oig.hhs.gov/publications/redbook.html
http://www.oig.hhs.gov/publications/orangebook.html

14. What comprehensive procedures or programs to verify provider eligibility (e.g., valid license; no criminal record; has not been excluded from other Federal health programs; practices from a legitimate business location) could OIG identify to strengthen pre-screening of providers with the goal of reducing Medicaid fraud?

Answer. Placing new providers on a 6-month prepayment review is one possibility. Another is requiring surety bonds. These steps would be especially helpful for DME providers where experience has shown that where large scale fraud exists, it generally occurs in the first few months of a company's existence. Often once the problem is detected, the providers typically close their doors or begin billing under different provider numbers. Another possibility would be to establish thresholds programmed into the Medicaid payment systems to detect "above the average" claims for the initial enrollment period. This would lessen the provider burden of waiting for its funds and allow the Government to focus efforts upon providers that appear to be exhibiting potentially fraudulent behavior. These thresholds could be established on a State-by-State basis.

15. Do current safeguards exist to assure that Federal dollars are expended only for a State's actual expenditures - not including any amount paid to a provider, which has then been returned to the State from the provider?

Answer. CMS has been taking steps through its State Plan Amendment review process to help ensure that Federal Medicaid funds are only available for States' actual expenditures. In recent years, CMS has been working with States to halt financial mechanisms involving Medicaid payments returned to the State from the provider. CMS identified 33 States that were using this type of financing mechanism. CMS believes that 26 of the 33 States have halted the practice because of CMS's strong corrective actions in reviewing the State plans. CMS continues to work with additional States to eliminate this financing mechanism.

The Administration has proposed amending the Medicaid statute to ensure that all future Federal matching funds are available only for a State's actual expenditures. The amendment would preclude Federal matching funds for payments to State or local governmental providers that (1) are not retained under control of the provider for the purpose of furnishing Medicaid care and services, or (2) are either returned to the State or local government, or (3) are used to supplant other State or local funding obligations. We support this proposed amendment.